Partners in Care FOUNDATION

The Social Determinants Innovators

Proven Results

Don't just take our word that Partners' interventions work. These studies demonstrate the effectiveness of our approach. We can provide additional detail on any or all of these on request.

Intervention	Partner/Payer	Population	Intervention Group	Comparison Group	Comparison Result	Intervention Result
HomeMeds Plus	UCLA Health	MA & Commercial med group	LACE score 11+ n=345	LACE score 11+ n=363	26.9% Readmission rate	10.4% readmission rate
Care Transition Choices	CMS – CCTP; Results contained in Health Services Advisory Group (HSAG) SQUIRE Report	FFS Medicare	Various targeting criteria – about 30% of discharges	Matched group of discharges		▪ Lower mortality up to 365 days post-d/c (p≤.013) ▪ 30 & 60-day readmission rates lower (p≤.004) ▪ Avg. MSPB* lower at 30, 60 & 90 days (p≤.01) by $1,600+
Care Transition Choices	CMS – CCTP via quarterly reports	FFS Medicare	Over 32,000 high-risk patients referred by 11 hospitals	11 hospitals baseline all-cause, all-hospital readmit rate pre-2011	Avg. 20.7% Readmission rate	Avg. 13.3% readmission rate
Care Transition Choices	CMS – CCTP via Mathematica/ Econometrica Final CCTP evaluation	FFS Medicare Glendale Collaborative	CCTP participants who received intervention	Matched comparison – significant findings reported		▪ Readmission rate 10.21% lower; ▪ 30-day post-d/c Part A&B expenditures 31.39% lower ▪ lower net difference in Part A&B expenditures $13,655,145 after accounting for avg. PEDR**.
Care Transition Choices	CMS – CCTP	FFS Medicare UCLA Health med group	Subset of UCLA CCTP who are in UCLA med group	Propensity-score matched discharges		Numbers embargoed pending publication ▪ Decreased 30, 60 and 90-day readmissions and 30-day ED use.
Blue Shield – CM HomeMeds Plus	Blue Shield of California	Commercial, Medicare & Exchange members	Received home visit from Partners at Home Network	Usual care by RN case manager		Double the rate of improvement in medication adherence
HomeMeds Plus	HealthCare Partners physician group	Medicare patients being discharged	Patients who received home visit after discharge	Patients who qualified but did not receive the intervention		▪ 63% had medication-related problems deemed by pharmacist to need MD intervention ▪ 12.7% lower use of emergency room within 30 days of discharge ▪ 24% lower readmission rate within 30 days of discharge
HomeMeds	Vanderbilt study of VNA-LA and VNS-NY	Home health patients	130 patients receiving pharmacist review	129 usual care patients dealt with by home health nurse	▪ TD improved in 24% ▪ Cardiac med use improved in 18% ▪ Medication use improved in 38%	▪ Therapeutic duplication (TD) improved in 71% of patients ▪ Cardiac med use improved in 55% of patients ▪ Overall medication use improved in 50% of patients